		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0017996

Facility Name: Southgate Health Care Center

Address: 900 East 9th St. (Number) Metropolis (City) 62960 (Zip Code)

County: Massac

Telephone Number: (618) 524-2683 **Fax #** (618) 524-3048

IDPA ID Number: 370993462001

Date of Initial License for Current Owners: 01/01/1964

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael G. Kaplan **Telephone Number:** 312-634-3400
Altschuler, Melvoin & Glasser LLP
One South Wacker Drive
Chicago, IL 60606-3392
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, One South Wacker Drive, Chicago, Il 60606-3392
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	74	Skilled (SNF)	74	27,084	1
2		Skilled Pediatric (SNF/PED)			2
3	66	Intermediate (ICF)	66	24,156	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,240	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,146	9	5,294	6,449	8
9	SNF/PED					9
10	ICF	27,177	4,145	1,526	32,848	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,323	4,154	6,820	39,297	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.69%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 08/25/1972

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 38 and days of care provided 4,443

Medicare Intermediary AdminaStar (Louisville, KY)

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7 **	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	134,828	12,675	8,323	155,826		155,826		155,826			1
2	Food Purchase		152,729		152,729		152,729		152,729			2
3	Housekeeping	92,511	16,349		108,860		108,860		108,860			3
4	Laundry	66,986	11,540	255	78,781		78,781		78,781			4
5	Heat and Other Utilities			68,853	68,853		68,853		68,853			5
6	Maintenance	55,960	11,364	24,038	91,362		91,362		91,362			6
7	Other (specify):*											7
8	**TOTAL General Services**	350,285	204,657	101,469	656,411		656,411		656,411			8
	B. Health Care and Programs											
9	Medical Director			3,775	3,775		3,775		3,775			9
10	Nursing and Medical Records	798,784	59,475	2,795	861,054		861,054		861,054			10
10a	Therapy			339,109	339,109		339,109		339,109			10a
11	Activities	65,569	1,025		66,594		66,594		66,594			11
12	Social Services	38,469			38,469		38,469		38,469			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	902,822	60,500	345,679	1,309,001		1,309,001		1,309,001			16
	C. General Administration											
17	Administrative	169,693			169,693		169,693		169,693			17
18	Directors Fees											18
19	Professional Services			29,609	29,609		29,609	(869)	28,740			19
20	Dues, Fees, Subscriptions & Promotions			17,597	17,597		17,597	(5,768)	11,829			20
21	Clerical & General Office Expenses	117,162	17,039	43,994	178,195		178,195	(2,004)	176,191			21
22	Employee Benefits & Payroll Taxes			233,140	233,140		233,140		233,140			22
23	Inservice Training & Education			1,669	1,669		1,669		1,669			23
24	Travel and Seminar			11,499	11,499		11,499	(4,616)	6,883			24
25	Other Admin. Staff Transportation			1,685	1,685		1,685		1,685			25
26	Insurance-Prop.Liab.Malpractice			50,956	50,956		50,956		50,956			26
27	Other (specify):*											27
28	**TOTAL General Administration**	286,855	17,039	390,149	694,043		694,043	(13,257)	680,786			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,539,962	282,196	837,297	2,659,455		2,659,455	(13,257)	2,646,198			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Southgate Health Care Center #0017996 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7 **	8	9	10	
30	Depreciation			91,322	91,322		91,322	33,290	124,612			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			63,340	63,340		63,340	(3,935)	59,405			32
33	Real Estate Taxes			16,000	16,000		16,000		16,000			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,682	1,682		1,682		1,682			35
36	Other (specify):*											36
37	**TOTAL Ownership**			172,344	172,344		172,344	29,355	201,699			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	88,440	83,225	28,242	199,907		199,907		199,907			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,860	76,860		76,860		76,860			42
43	Other (specify):* Nonallowable costs			596,178	596,178		596,178	(596,178)				43
44	**TOTAL Special Cost Centers**	88,440	83,225	701,280	872,945		872,945	(596,178)	276,767			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,628,402	365,421	1,710,921	3,704,744		3,704,744	(580,080)	3,124,664			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	33,290	30		9
10	Interest and Other Investment Income	(3,577)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(322)	43		13
14	Non-Care Related Interest	(358)	32		14
15	Non-Care Related Owner's Transactions	(6,195)	43		15
16	Personal Expenses (Including Transportation)	(9,076)	43		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(5,848)	43		19
20	Contributions	(960)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(869)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(572,552)	43		24
25	Fund Raising, Advertising and Promotional	(716)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(193)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,004)	21		28
29	Other-Attach Schedule See attached schedule	(10,700)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (580,080)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	-		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (580,080)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Southgate Health Care Center

ID# 0017996

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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26				26
27				27
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68				68
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70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	0		90

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jane Ann Parker	86.00%					
Sam Thompson	4.67%					
Jeff Thompson	4.67%					
Shelly MacCauley	4.66%	N/A		N/A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V				N/A				4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Sam Thompson	Operations	Administrative	4.67%	None	40+	66.67	Salary	$ 108,901	17(1)	1
2	Jeff Thompson	Maintenance	Maintenance	4.67%	None	40+	100.00	Salary	24,539	6(1)	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 133,440		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4				N/A						4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Community National Bank		X	Mortgage	$12,689.00	11/01/97	$ 1,300,000	$ 590,072	12/14/01	0.0825	$ 58,797	1
2	Banterra Bank		X	Purchase vehicle	$360.00	08/24/00	11,154	10,082	08/23/03	0.1000	358	2
3	Banterra Bank		X	Purchase vehicle	$948.00	08/24/00	29,810	26,891	08/23/03	0.0900	876	3
4												4
5												5
	Working Capital											
6	Community National Bank		X	Line of Credit	demand	05/01/98	30,000	-0-		0.0900	2,951	6
7												7
8	State of Illinois		X	Late payment	n/a			-0-			358	8
9	TOTAL Facility Related				$13,997.00		$ 1,370,964	$ 627,045			$ 63,340	9
	B. Non-Facility Related*											
10								Less: Interest income offset			(3,577)	10
11								Non-allowable interest			(358)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,935)	14
15	TOTALS (line 9+line14)						$ 1,370,964	$ 627,045			$ 59,405	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$ a	16,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	$	15,768	2
3. Under or (over) accrual (line 2 minus line 1).		$	(232)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$ b	16,232	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	16,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	12,294	8
1996	14,294	9
1997	15,376	10
1998	15,241	11
1999	15,768	12

a= Prior year accrual	22,597	
Prior year over accrual	(6,597)	b= Estimated tax due adjusted for prior year
Restated 2000 accrual	16,000	

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,622 B. General Construction Type: Exterior Brick Frame Concrete block Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care	185,000	1972	$ 5,000	1
2					2
3	TOTALS	185,000		$ 5,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88		1972	1972	$ 207,276	$ 7,677	30	$ 6,909	$ (768)	$ 176,180	4
5	37			1976	289,344	10,716	30	9,645	(1,071)	236,303	5
6	10			1989	583,147	18,513	30	19,438	925	223,237	6
7	5 (a)			1993	598,429	15,344	30	19,948	4,604	149,610	7
8			Completed 93 addition		13,658	350	30	455	105	3,175	8
	Improvement Type**										
9	Land improvements			1975	7,341		10-30			7,012	9
10	Land improvements			1976	2,886		20			2,886	10
11	Building improvements			1977	1,098		28			1,098	11
12	Land and building improvements			1980	1,014		20			1,014	12
13	Building improvements			1981	57,891		15			57,891	13
14	Land & building improvements			1982	17,279		5-20			17,279	14
15	Building improvements			1983	675		10			675	15
16	Bushes & gravel			1984	888		10			888	16
17	Patio, Med room & improvements			1984	13,078		15			13,078	17
18	Building addition			1984	100,925		20	5,046	5,046	85,782	18
19	Gravel road & painting			1985	7,365		3-20			7,365	19
20	Improvements			1985	17,960		15	602	602	17,960	20
21	Fire alarm & barn			1985	3,568		20	179	179	2,774	21
22	Improvements			1986	13,163		15	877	877	12,717	22
23	Kitchen remodeling			1988	32,477	1,031	30	1,084	53	13,538	23
24	Overhead door/kitchen			1989	852		15	57	57	655	24
25	Flooring			1990	729	36	10	36		729	25
26	Fire alarm			1990	9,537	304	20	477	173	5,008	26
27	Dining room improvements			1992	1,824	58	10	183	125	1,548	27
28	Warehouse storage building			1993	17,802	590	30	593	3	4,744	28
29	100 gal lime tank			1995	3,742	327	15	250	(77)	1,375	29
30	Drywall resident rooms & bathrooms			1996	2,240	57	10	225	168	1,009	30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 2,006,188	$ 55,003		$ 66,004	$ 11,001	$ 1,045,530	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

(a) 24 new beds less 19 old beds = 5 additional beds

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking lot			1997	5,000	411	10	500	89	1,750	9
10	Flooring			1997	674	17	10	68	51	206	10
11	Kitchen plumbing			1997	1,947	50	20	97	47	340	11
12	Tile floor			1997	784	20	10	78	58	273	12
13	Water softener			1997	667	17	10	67	50	234	13
14	Interior design			1997	1,245	32	15	83	51	291	14
15											15
16	Flooring			1998	1,130	29	10	113	84	282	16
17											17
18	Roofing			1999	17,240	442	20	862	420	1,616	18
19											19
20	Roof - Section B			2000	31,346	55	20	425	370	425	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 60,033	$ 1,073		$ 2,293	$ 1,220	$ 5,417	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 382,387	$ 6,981	$ 55,499	$ 48,518	5-10	$ 310,867	37
38	Current Year Purchases	11,418	10,780	816	(9,964)	7	816	38
39	Fully Depreciated Assets	190,589					190,589	39
40								40
41	TOTALS	$ 584,394	$ 17,761	$ 56,315	$ 38,554		$ 502,272	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Resident care	1989 Chevrolet van	1989	$ 18,500	$	$	$	4	$ 18,500	42
43	Resident care	1983 Ford pickup	1987	4,700				4	4,700	43
44	Resident care	1999 Dodge Dakota	2000	14,504	3,060		(3,060)			44
45										45
46	TOTALS			$ 37,704	$ 3,060	$	$ (3,060)		$ 23,200	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,693,319	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 76,897	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 124,612	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 47,715	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,576,419	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	1991 Mercedes Benz (1993)	$ 43,500	$ 1,675	$ 18,035	52
53	1996 Jeep (1995)	30,199	1,775	14,685	53
54	1999 Suburban (2000)	29,810	10,975	10,975	54
55					55
56					56
57	TOTALS	$ 103,509	$ 14,425	$ 43,695	57

G. Construction-in-Progress

	Description	Cost	
58	Arch fees-Laundry addn: 2000	$ 5,389	58
59			59
60			60
61	Total	$ 5,389	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		N/A		$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 1,682 Description: Dietary equipment - 1,092; Nursing equipment - 590
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO
   It is the policy of this facility to only hire certified nurses aides.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

N/A

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	7,552	$ 94,405	$	7,552	$ 94,405	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		15,358	172,778		15,358	172,778	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		5,754	71,926		5,754	71,926	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				69,138		69,138	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39(1), (3)	11,035 hours	88,440	1,895	23,305		1,895	111,745	12
13	Laboratory Other (specify): VA ancillary costs	39(3) 39(2), (3)				2,069 2,868	14,087		2,069 16,955	13
14	TOTAL			$ 88,440	30,560	$ 367,351	$ 83,225	30,560	$ 539,016	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center **#** 0017996 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 103,244	$ 103,244	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 316,036)	840,953	840,953	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	79,884	79,884	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	14,624	14,624	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	3,135	3,135	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,041,840	$ 1,041,840	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,000	5,000	13
14	Buildings, at Historical Cost	2,058,915	2,066,221	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	725,607	622,098	16
17	Accumulated Depreciation (book methods)	(1,729,966)	(1,576,419)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): See attached	5,389	5,389	22
23	Other(specify): See attached	1,627	1,627	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,066,572	$ 1,123,916	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,108,412	$ 2,165,756	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 114,680	$ 114,680	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	36,973	36,973	29
30	Accrued Salaries Payable	43,550	43,550	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,879	4,879	31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,232	16,232	32
33	Accrued Interest Payable	2,840	2,840	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached	46,753	46,753	36
37	Deferred resident income	84,021	84,021	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 349,928	$ 349,928	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	590,072	590,072	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 590,072	$ 590,072	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 940,000	$ 940,000	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,168,412	$ 1,225,756	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,108,412	$ 2,165,756	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,133,384	1
2	Restatements (describe):		2
3			3
4	Prior period adjustment	(14,881)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,118,503	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	280,306	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(230,397)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 49,909	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,168,412	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,107,560	1
2	Discounts and Allowances for all Levels	(143,113)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,964,447	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	896,865	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 896,865	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	99,221	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	18,348	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 117,569	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,577	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,577	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending income	1,956	28
28a	Other income	636	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,592	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,985,050	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	656,411	31
32	Health Care	1,309,001	32
33	General Administration	694,043	33
	B. Capital Expense		
34	Ownership	172,344	34
	C. Ancillary Expense		
35	Special Cost Centers	796,085	35
36	Provider Participation Fee	76,860	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,704,744	40
41	**Income before Income Taxes (line 30 minus line 40)****	280,306	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 280,306	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 29,548	$ 14.21	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,909	10,381	153,914	14.83	3
4	Licensed Practical Nurses	22,029	23,152	225,975	9.76	4
5	Nurse Aides & Orderlies	64,708	66,624	423,604	6.36	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,500	4,980	35,897	7.21	8
9	Activity Director	2,000	2,080	21,303	10.24	9
10	Activity Assistants	5,817	6,205	44,266	7.13	10
11	Social Service Workers	4,107	4,219	38,469	9.12	11
12	Dietician					12
13	Food Service Supervisor	1,860	1,940	19,690	10.15	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,279	19,004	115,138	6.06	15
16	Dishwashers					16
17	Maintenance Workers	4,389	4,389	55,960	12.75	17
18	Housekeepers	15,890	16,602	92,511	5.57	18
19	Laundry	10,322	10,720	66,986	6.25	19
20	Administrator	2,000	2,080	60,792	29.23	20
21	Assistant Administrator					21
22	Other Administrative	2,000	2,080	108,901	52.36	22
23	Office Manager					23
24	Clerical	10,447	10,707	117,162	10.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,328	2,453	18,286	7.45	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	182,585	189,696	$ 1,628,402 *	$ 8.58	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	248	$ 8,323	1(3)	35
36	Medical Director	46	3,775	9(3)	36
37	Medical Records Consultant	32	1,595	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,200	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	422	$ 14,893		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Michelle L. Cavitt	Administrator	0.00%	60,792
Sam B. Thompson	Administrative	4.67%	108,901
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 169,693

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
American Expr Tax & Bus. Svcs	Accounting	$ 7,043
Kemper CPA	Accounting	7,228
Altschuler, Melvoin & Glasser LLP	Accounting	6,369
Whitlow, Roberts, *et.al.*	Legal	7,171
American Health Care Assn	Software consulting	785
One Main	Internet consultant	420
T. Williamson	Temporary accounting svcs	537
Hardin Co. Abstract Co.	Title search	56
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 29,609

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,523
Unemployment Compensation Insurance	17,309
FICA Taxes	124,557
Employee Health Insurance	12,818
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee morale	20,436
401(k) contribution	8,077
Personnel costs & employee reimbursements	1,420
TOTAL (agree to Schedule V, line 22, col.8)	$ 233,140

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,821
Health Care Worker Background Check	
(Indicate # of checks performed 100)	1,228
Illinois Health Care Assn dues + PAC	5,784
Chamber of Commerce & Kiwanis dues	380
National Assn of Geriatrics-CNA program	1,509
Miscellaneous dues	650
Miscellaneous subscriptions	23
HCFA CLIA lab license	150
Less: Public Relations Expense	(380)
IHCA PAC contributions	(336)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,829

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See attached detail	6,883
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,883

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4					N/A								
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center **#** 0017996 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association-5,448**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,777** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **76,860**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.